Adolescent Opioid Misuse

Peter Ziemkowski, MD, FAAFP

ACTIVITY DISCLAIMER

The material presented here is being made available by the American Academy of Family Physicians for educational purposes only. Please note that medical information is constantly changing; the information contained in this activity was accurate at the time of publication. This material is not intended to represent the only, nor necessarily best, methods or procedures appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

The AAFP disclaims any and all liability for injury or other damages resulting to any individual using this material and for all claims that might arise out of the use of the techniques demonstrated therein by such individuals, whether these claims shall be asserted by a physician or any other person. Physicians may care to check specific details such as drug doses and contraindications, etc., in standard sources prior to clinical application. This material might contain recommendations/guidelines developed by other organizations. Please note that although these guidelines might be included, this does not necessarily imply the endorsement by the AAFP.
DISCLOSURE

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this session have indicated they have no relevant financial relationships to disclose.

The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated: Some medications used for Medication-Assisted are not approved for use below age 16, though are advocated for use by several studies and guidelines. We will review use of buprenorphine, naloxone, naltrexone and methadone in patients down to age 13. The FDA-approved uses will always be noted.

Peter Ziemkowski, MD, FAAFP

Associate Professor, Department of Family and Community Medicine, Western Michigan University Homer Stryker, MD, School of Medicine, Kalamazoo

Dr. Ziemkowski is a graduate of the University of Illinois at Chicago and completed his family medicine residency at the Michigan State University Kalamazoo Center for Medical Studies. He practices family medicine in southwest Michigan, where he is on the faculty of the Western Michigan University Homer Stryker, MD, School of Medicine’s Family Medicine Residency Program and serves as associate dean for Student Affairs. He has been teaching for 20 years and maintains a blog for residents. Dr. Ziemkowski is board certified in family medicine, and he is also certified by the American Board of Preventive Medicine (ABPM) in clinical informatics. He seeks to use technology to help educate patients on healthy lifestyles. Other clinical interests include the care of metabolic conditions associated with cardiovascular risk, including hypertension, hyperlipidemia, diabetes, and obesity. He believes that primary prevention of these diseases and their complications will deliver the greatest benefit to the greatest number of patients.
Learning Objectives

1. Implement a validated tool to screen adolescents for opioid misuse.

2. Identify brief intervention and referral options for adolescents who are misusing opioids.

3. Describe characteristics of adolescent neurobiology and impact on risk for substance abuse.

4. Describe medication assisted therapy options for adolescent patients with opioid use disorders.

Audience Engagement System
Substance Use Among Teens

- The CDC Reports:
  - Alcohol, marijuana, and tobacco are substances most commonly used by adolescents.
  - By 12th grade, about two-thirds of students have tried alcohol.
  - About half of 9th through 12th grade students reported ever having used marijuana.
  - About 4/10 9th through 12th grade students reported having tried cigarettes.
  - Among 12th graders, close to 2/10 reported using prescription medicine without a prescription.
  - 12 to 20 years of age consume about one-tenth of all alcohol consumed in the United States.


AES Question #1

Which of the following types of opioids has lead to the greatest number of overdose deaths among those ages 15 to 24 over the last 5 years for which date is available? (2012-2017)

A. Prescription Opioids
B. Prescription Opioids mixed with Synthetic Narcotics
C. Heroin
D. Heroin mixed with Synthetic Narcotics
E. Other Synthetic Narcotics (fentanyl)
Opioid Deaths by Type: 15-24 y/o

Slang

- “Sizzurp, Lean, Purple Drank”
  - Codeine/promethazine cough syrup + soft drink (+/- hard candy)
  - Popularized by hip-hop in 90’s
    - at least 4 hip-hop star deaths
  - Many death/hospitalizations

https://commons.wikimedia.org/wiki/Category:Purple_drank#/media/File:Purple_Drank.jpg

Opioid Use Disorder (OUD)

• What is OUD?
  – OUD is defined in the DSM-5 as a problematic pattern of opioid use leading to clinically significant impairment or distress.
  – OUD was previously classified as Opioid Abuse or Opioid Dependence in DSM-IV.
DSM-5 Diagnostic Criteria for OUD

- In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:
  - Opioids are often taken in larger amounts or over a longer period than was intended.
  - There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
  - A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
  - Craving, or a strong desire or urge to use opioids.
  - Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.

- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Exhibits tolerance.
- Exhibits withdrawal.

Adolescent Neurobiology

“The adolescent brain is often likened to a car with a fully functioning gas pedal (the reward system) but weak brakes (the prefrontal cortex)”

Adolescent Neurobiology

• More vulnerable to temptation
  – Reward pathways develop before prefrontal cognition
• Sustained substance use affect neuropsychological functioning
  – Results in attention deficits, memory problems and decreased cognitive flexibility


“While many social and cultural factors affect drug use trends, when young people perceive drug use as harmful, they often reduce their level of use.”

Screening Tools

• “81% of patients seeking SUD treatment had been seen by a primary care physicians the previous year.”


SBIRT

• Screening,
• Brief Intervention,
• Referral to Treatment
• = SBIRT
Single Question Screening

• “How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?”
  – Nonmedical = “For instance, because of the experience or feeling it caused.”


Drug Abuse Screening Test

• DAST
  – 10 questions or 20 questions
  – Scored Yes=1/No=0
    • (except Q 3 = 1 point for No)

• DAST-10 Scoring
  – 0 points = low risk
  – 1-3 points = moderate risk
    • Monitor/reassess
  – > 3 points = substance abuse/dependence

• Sensitivity = 90% to 100%
• Specificity = 77%

### DAST-10

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer “Yes”)
4. Have you had "blackouts" or "flashbacks" as a result of drug use?
5. Do you ever feel bad or guilty about your drug use? (If never use drugs, choose "No")
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?


### A Primary Care Approach

- **Hazardous Use**
  - Infrequent
  - Risks health/dependence
- **Substance abuse**
  - Consequences from use
- **Substance dependence**
  - Chronic relapsing illness

A Primary Care Approach

– Brief Counseling
  • “Motivational Interviewing has been show to decrease quantity and frequency of drug and alcohol use.”
  • Elicit patients own reasons for change


CRAFFT Screening Test

• 6 questions:
  – Car, Relax, Alone, Forget, Friends, Trouble
• For under age 21
  – American Academy of Pediatrics' Committee on Substance Abuse recommended
• Screens for simultaneous risky alcohol and other drug use disorders

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

**Part A**
During the **PAST 12 MONTHS**, did you:

1. Drink any alcohol (more than a few sips)?
   - No [ ] Yes [ ]

2. Smoke any marijuana or hashish?
   - No [ ] Yes [ ]

3. Use anything else to get high?
   - "anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"
   - No [ ] Yes [ ]

For clinic use only: Did the patient answer “yes” to any questions in Part A?

- No [ ] Yes [ ]

Ask CAR question only, then stop

Ask all 6 CRAFFT questions

**Part B**

1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
   - No [ ] Yes [ ]

2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or **fit in**?
   - No [ ] Yes [ ]

3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?
   - No [ ] Yes [ ]

4. Do you ever **FORGET** things you did while using alcohol or drugs?
   - No [ ] Yes [ ]

5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
   - No [ ] Yes [ ]

6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?
   - No [ ] Yes [ ]

**SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY**

CRAFFT Score:
- 1 point for each "Yes" response in Part B.
- A score of 0 or higher is a positive screen indicating a need for additional assessment.

**Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score:**

- 0: 1%
- 1: 2%
- 2: 3%
- 3: 5%
- 4: 10%
- 5: 20%
- 6: 35%

**CRAFFT Score Chart** (Abbreviated)

<table>
<thead>
<tr>
<th>Probability of Substance Abuse/Dependence Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: 1%</td>
</tr>
<tr>
<td>1: 2%</td>
</tr>
<tr>
<td>2: 3%</td>
</tr>
<tr>
<td>3: 5%</td>
</tr>
<tr>
<td>4: 10%</td>
</tr>
<tr>
<td>5: 20%</td>
</tr>
<tr>
<td>6: 35%</td>
</tr>
</tbody>
</table>

**REFERENCES**


**Screening Tools**

- **POSIT**
  - Problem Oriented Screening Instrument for Teenagers
    - **Age 12-19**
    - Questionnaire, 139 yes/no questions, 20-30 minutes

- **NIH:** National Institute on Drug Abuse (NIDA)
  - Screening and Assessment Tools Chart

- https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
NIH: NIDA Tools for Adolescents

- Online tools for ages 12-17
- Take less than 2 minutes each
- Validated in adolescents
- Very similar
- Suggest you use the one best suited to your practice
  1. BSTAD:
     Brief Screener for Tobacco, Alcohol and other Drugs
     https://www.drugabuse.gov/ast/bstad/#/
  2. S2BI:
     Screening to Brief Intervention
     https://www.drugabuse.gov/ast/s2bi/#/

- 3 questions about frequency of:
  - Tobacco
  - Alcohol
  - Marijuana
- Those reporting use of any of these 3 are then asked about additional substance use.
- Divided into 3 categories
  - No reported use / Lower risk / Higher risk

From: https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/screening-tools-for-adolescent-substance-use
Accessed: July 20, 2019
Confidentiality

• Confidentiality in adolescent health visit is predictor of the number and subject of issues discussed
• Split-visit model
  – Parents in clinical visits for limited time
  – Offer exams and counseling separately as well.
  – Must explain benefits to both, clarify boundaries.

“...adolescents’ access to confidential healthcare is important for their health and well-being, while also recognizing the benefit of supportive parental involvement.”

From: https://www.aafp.org/about/policies/all/adolescent-confidentiality.html
Accessed: July 20, 2019

Principles of Treatment

• Behavioral approach
• Family-based approach
• Addiction Medications
  – Buprenorphine
  – Methadone
  – Naltrexone
• Recovery Support Services

Principles of Treatment

1. Adolescent substance use needs to be identified and addressed as soon as possible.
2. Adolescents can benefit from a drug abuse intervention even if they are not addicted to a drug.
3. Routine annual medical visits are an opportunity to ask adolescents about drug use.
4. Legal interventions and sanctions or family pressure may play an important role in getting adolescents to enter, stay in, and complete treatment.
5. Substance use disorder treatment should be tailored to the unique needs of the adolescent.


Principles of Treatment

6. Treatment should address the needs of the whole person, rather than just focusing on his or her drug use.
7. Behavioral therapies are effective in addressing adolescent drug use.
8. Families and the community are important aspects of treatment.
9. Effectively treating substance use disorders in adolescents requires also identifying and treating any other mental health conditions they may have.
10. Sensitive issues such as violence and child abuse or risk of suicide should be identified and addressed.

Principles of Treatment

11. It is important to monitor drug use during treatment.
12. Staying in treatment for an adequate period of time and continuity of care afterward are important.
13. Testing adolescents for sexually transmitted diseases like HIV, as well as hepatitis B and C, is an important part of drug treatment.


AES Question #2

What percentage of diagnosed Opioid Use Disorder patients younger than 18 received Medication-Assisted Treatment?

A. <2%
B. 5%
C. 10%
D. 25%
MAT in Adolescents

• AAP Policy Statement
  – Medication-Assisted Treatment of Adolescents with Opioid Use Disorders
    • “Opioid use disorder is a leading cause of morbidity and mortality among US youth. Effective treatments, both medications and substance use disorder counseling, are available but underused, and access to developmentally appropriate treatment is severely restricted for adolescents and young adults. Resources to disseminate available therapies and to develop new treatments specifically for this age group are needed to save and improve lives of youth with opioid addiction.”

AAP Policy Statement—Recommendations

1. Opioid addiction is a chronic relapsing neurological condition.
   – Rates of spontaneous recovery are low
   – Outcomes can be improved with MAT
   – AAP advocates for resources to improve access to MAT.

2. AAP recommends offering or referring to MAT for adolescents and young adults.

3. AAP supports further research on developmentally appropriate treatment for substance use disorders.
American Society of Addiction Medicine

1. Clinicians should consider treating adolescents who have opioid use disorder using the full range of treatment options, including pharmacotherapy.

2. Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment of opioid use disorder in adolescents. Age is a consideration in treatment, and federal laws and US FDA approvals need to be considered for patients under the age 18. Buprenorphine is US FDA-approved for adolescents aged 16 years and above.

3. Psychosocial treatment is recommended in the treatment of adolescents with opioid use disorder.

4. Concurrent practices to reduce infection (eg, sexual risk reduction interventions) are recommended as components of comprehensive treatment for the prevention of sexually transmitted infections and blood-borne viruses.

5. Adolescents may benefit from treatment in specialized treatment facilities that provide multidimensional services.


---

Medication–Assisted Treatment

- **Opioid Agonists**
  - Methadone
  - Buprenorphine

- **Opioid Antagonist**
  - Naltrexone
  - (Naloxone – used w/ Buprenorphine)

- **Not FDA approved for pediatric use!**
  - Adolescent buprenorphine use based on two studies
  - Naltrexone used off-label in adolescents
  - Methadone programs usually restricted to 18 or older
Medication Assisted Treatment (MAT)

• Do not just replace one drug for another!
  – Relieve withdrawal symptom and psychological cravings
  – At proper dose, have no effect on intelligence, mental capacity, physical functioning, or employability.

• All medications used in Medication-Assisted Treatment (MAT) are prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

AES Question #3

James is a 16 y/o male high school student who is seen for a sports physical. His S2BI screening notes that he is at Higher Risk of Drug Use. Further evaluation notes that he meets the criteria for Opioid Use Disorder. He finds it difficult to avoid taking opioids for more than a few days. Appropriate behavioral therapies are initiated and it’s decided to start Medication-Assisted Treatment. What is the best option to consider for MAT for James?

A. Naloxone  
B. Naltrexone  
C. Buprenorphine  
D. Buprenorphine/Naloxone  
E. Methadone
Methadone

- Full opioid agonist
  - Pain relief = 4-8 hours
  - half-life = 24-55 hours
- Less euphoria, blocks withdrawal from other opioids
- Can only be dispensed through SAMHSA-approved Opioid Treatment Programs
  - Limited access

- Long-established effective treatment for opioid addiction
  - But
- Most methadone programs prohibit patients under 18!

Buprenorphine

- Partial opioid agonist
  - Less euphoria/respiratory depression
  - Long-acting/once-daily dosing
  - Effects level off despite dose increases
    - “Ceiling effect”
- First opioid dependency treatment prescribed or dispensed in physician offices!

- Compared to non-pharmacologic treatment of OUD, MAT w/ Buprenorphine is more effective in:
  - Reducing opioid use
  - Retaining patients in treatment
  - Reducing risk of overdose death
Naltrexone / (Naloxone)

- Non-selective/competitive opioid antagonists
  - Blocks the euphoric / sedating effects of other opioids
- Naloxone
  - Very poor oral and GI tract absorption

- Naltrexone
  - Oral or IM
  - Reported to reduce opioid cravings
  - On relapse, prevents feeling of “getting high”
    - but reduces tolerance to opioids.

Naltrexone

- Must be opioid free for 7-10 days prior to starting treatment
- Consider "challenge test" if risk of withdrawal
  - Measures symptoms
  - Give small dose of naloxone (0.2-0.8 mg IM)
  - Observe for withdrawal

- Dosing:
  - PO naltrexone (ReVia)
    - 25 mg PO
      - Observe for 1 hour, if no withdrawal, give another 25 mg
    - then 50 mg/day
  - IM (Vivitrol)
    - 380 mg once a month
- “You have an important role to play in addressing this public health crisis.”

VADM Jerome M. Adams, MD, MPH
U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose
April 2018
https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html#ftn6

Surgeon General’s Report

- Patients/Public
  - Talk to your doctor about getting Naloxone
  - Learn signs of opioid overdose
  - Get trained to administer in suspected overdose
  - Resources:
    - Prevent & Protect: www.prevent-protect.org

- Prescribers/Pharmacists
  - Identify patients at high risk for overdose
  - Follow CDC Guideline for Prescribing Opioids for Chronic Pain
  - Utilize state PDMP
  - Find out whether Rx needed in your state
  - Rx Naloxone to those at risk/friends & family
  - Prescribe to Prevent
    - www.prescribetoprevent.org
AES Question #4

Jean is a 17 y/o female high school student who is seen at 10 weeks gestation for an initial OB visit. Her S2BI screening notes that she is at Higher Risk of Drug Use. Further evaluation notes that she meets the criteria for Opioid Use Disorder with frequent misuse of Prescription opioids. Appropriate behavioral therapies are initiated and it’s decided to start Medication-Assisted Treatment. What is the best option to consider for MAT for Jean?

A. Naloxone  
B. Naltrexone  
C. Buprenorphine  
D. Buprenorphine/Naloxone  
E. Methadone

Buprenorphine/Naloxone

- Offset the risk of Buprenorphine abuse  
- Taken Orally  
  - Buprenorphine effect predominates  
- Crushed and Injected  
  - Naloxone effect predominates  
  - Can bring on withdrawal

- Combination preferred  
  - Less likely to be abused/diverted  
- Buprenorphine alone in pregnant or lactating women
# Available forms/brands

<table>
<thead>
<tr>
<th><strong>Drug</strong></th>
<th><strong>Formulation</strong></th>
<th><strong>Maintenance Dose</strong></th>
<th><strong>~ Cost</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Buprenorphine</strong></td>
<td>2 &amp; 8 mg SL tabs</td>
<td>4-24 mg SL qd</td>
<td>$330: 60 8-mg tabs</td>
</tr>
<tr>
<td><strong>Probuphine (implant)</strong></td>
<td>74.2 mg subdermal implant</td>
<td>4 implants/6 months (equiv to 8mg SL/day)</td>
<td>$5176: 4-implants** (1294/month)</td>
</tr>
<tr>
<td><strong>Sublocade extended-release IM injection</strong></td>
<td>100 mg/0.5 mg 300 mg/1.5 ml</td>
<td>100 mg IM q month</td>
<td>$1658: 100 mg/0.5 mg</td>
</tr>
<tr>
<td><strong>Buprenorphine/naloxone (generic)</strong></td>
<td>2/0.5, 8/2 mg SL tabs</td>
<td>4/1 to 24/6 mg qd</td>
<td>$550: 60 8/2-mg tabs</td>
</tr>
<tr>
<td><strong>Bunavail buccal film (w/ naloxone)</strong></td>
<td>1.0/0.3, 2.0/0.7, 3.0/1.0 mg buccal films</td>
<td>2.1/0.3 – 12.6/2 mg qd</td>
<td>$530: 60 4.2/0.7-mg films</td>
</tr>
<tr>
<td><strong>Suboxone SL film (w/ naloxone)</strong></td>
<td>2/0.5, 4/1, 8/2, 12/3 mg SL films</td>
<td>4/1 – 24/6 mg qd</td>
<td>$540: 60 8/2-mg films</td>
</tr>
<tr>
<td><strong>Zubsolv SL tab (w/ naloxone)</strong></td>
<td>0.7/0.18, 1.0/0.36, 2.0/0.71, 5.0/1.4, 8.0/2.1, 11.0/2.9 mg SL tabs</td>
<td>2.9/0.71 – 17.2/4.2 mg qd</td>
<td>$530: 30 11.4/2.9-mg tabs</td>
</tr>
</tbody>
</table>

In general, products are not bioequivalent to each other.

*Approximate cost from goodrx.com unless otherwise noted (Accessed: July 24, 2019)

**Approximate cash cost from drugs.com (Accessed: July 24, 2019)

MAT w/ Buprenorphine

- FPs write more opioid Rx by volume than other physicians, but most don’t provide MAT.
- MAT w/ buprenorphine is an effective alternative to methadone and can be provided in primary care offices after obtaining a SAMHSA waiver.

Preparing office/team requires:
- Identify a practice champion.
- Assess practice readiness
- Set up office protocols
- Secure pharmacy, lab and counseling services
- Establish a clinical workflow


Buprenorphine treatment

  - 8 hour course
  - Contact SAMHSA
    - 1-866-287-2728
    - www.samhsa.gov/medication-assisted-treatment
- Allow physicians to treat increasing # patients with SAMHSA application:
  - 30 patients first year
  - 100 patients subsequent year(s)
  - May increase to 275 patients
Buprenorphine treatment

- Equally as effective as moderate methadone dose
- Phases
  1. Induction
  2. Stabilization
  3. Maintenance
- Approved for age 16 and above!

- Increased success with:
  - Stable or controlled
    - Medical comorbidities
    - Psychiatric condition
  - Safe, substance free environment
- Otherwise may benefit from specialty care setting.


Buprenorphine Initiation

- Drug testing, informed consent, treatment contract
- Should be in mild withdrawal
  - 8-12 hour abstinence
  - Use clinical scale (COWS)
  - If not, reschedule

- Dose titration in office
  - Monitor at 60-minute intervals until withdrawal symptoms abate
- Close follow-up in 1 day to 1 week
- Consider Clonidine Rx
  - 0.1 mg q 6-8 hours
- Consider Naloxone kit Rx

AES Question #5

James, our 16 y/o patient is started on appropriate MAT. At follow-up visits in the first few months of treatment, he reports occasional relapses. What is the best way to address such relapses?

A. No change to his current treatment.
B. He has failed MAT and it should be stopped immediately.
C. Increased visits/behavioral therapies.
D. Immediate up-titration of his MAT.
E. Change to an alternate medication for his MAT.

Buprenorphine Maintenance

- Drug titration to stable dose
  - Opioid use stops
  - Withdrawal abates
  - Cravings minimized
- Pill/wrapper counts
- Document relapse, cravings, withdrawal
- State Rx database check
- Random drug screen
- Initial occasional opioid use common
  - Increased visits
  - Behavioral tx
    - Cognitive behavioral therapy
    - Contingency management
    - Motivational enhancement
    - Case management

Practice Recommendations

- Consider screening all adolescents for substance use.
  - Simple, quick online tools are available.
- Refer or provide treatment to appropriate patients.
- Consider medication-assisted treatment in those over age 16 (buprenorphine).

Summary

- Adolescents are susceptible to opioid use disorder.
- Simple tools to screen for use/abuse in adolescents are available.
- Treatment can be affective.
- If appropriate, Medication-Assisted Treatment should be considered.
- Medication-Assisted Therapy with Buprenorphine can be provided in the Family Physician office.
- Family physicians are appropriate providers for opioid use disorder treatment.
Questions

Resources

• SAMHSA
  – SBIRT
    • https://www.integration.samhsa.gov/resource/sbirt-resource-page
  – Screening Tools
    • https://www.integration.samhsa.gov/clinical-practice/screening-tools

• American Academy of Pediatrics
  – Substance Use and Prevention
Resources

• NIH: (NIDA)
  – Screening and Assessment Tools Chart
    • https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

References

15. Editors FPM. How to obtain a waiver to treat opioid use disorder with buprenorphine [Internet]. [cited 2019 Jul 22]. Available from: https://www.aafp.org/journals/fpm/blogs/impractice/entry/opioid_use_disorder.html

References


